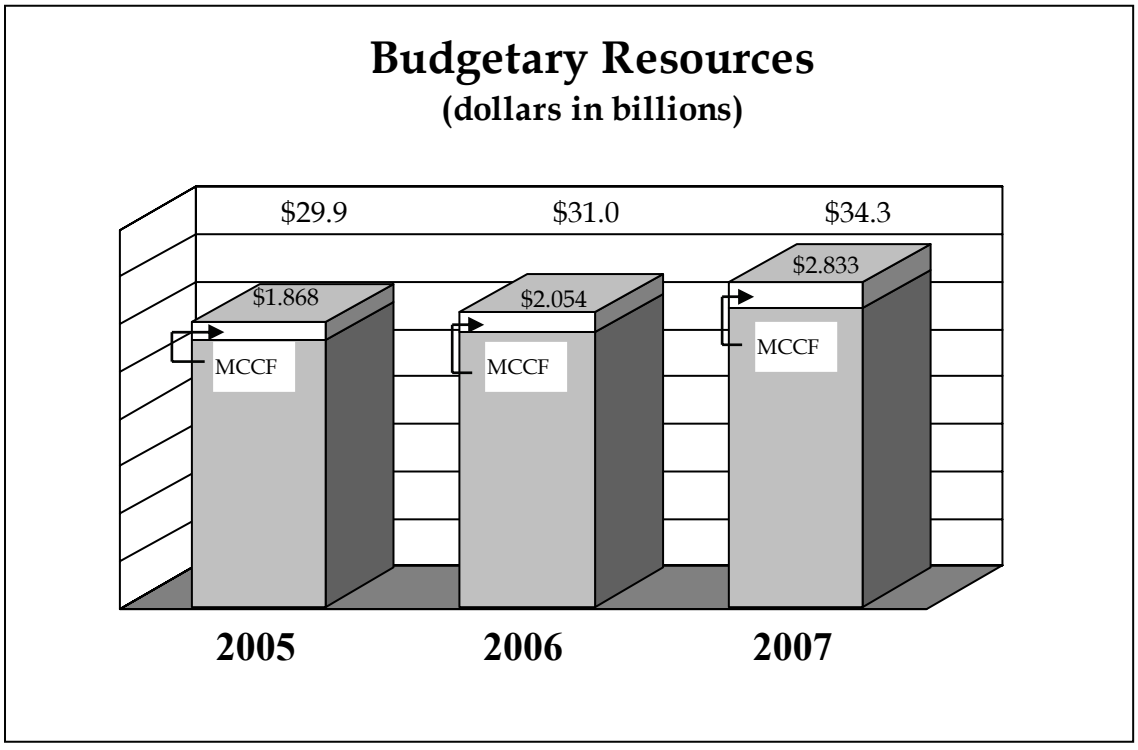
Medical Care Programs

The medical care programs are resourced through three appropriations: Medical Services, Medical Administration, and Medical Facilities. These three appropriations provide the resources to operate a comprehensive and integrated health care system that supports enrolled veterans; a national academic education and training program to enhance veterans' quality of care; administrative support for facilities. The mission of the veterans' health care system is to serve the needs of America's veterans. Enrolled veterans receive the needed specialized and primary medical care and related social support services. To accomplish this mission, the Veterans Health Administration (VHA) is a comprehensive, integrated health care system that provides excellence in health care value; excellence in service as defined by its customers; excellence in education and research; and excellence in timely and effective contingency medical support in the event of national emergency or natural disaster.



The 2007 President's budget request for the medical care program is comprised of three appropriations reflected in the table below. VA is requesting $24.7 billion for the Medical Services appropriation, an increase of 9.6 percent; $3.2 billion for Medical Administration, and increase of 8.5 percent; and $3.6 billion for Medical Facilities, a 8.2 percent increase. This will provide total budget authority of $34.3 billion, an increase of $3.5 billion, which represents an 11.3 percent increase over the 2006 estimate including $2.8 billion from the Medical Care Collections Fund (MCCF). This request includes a savings of $795 million in appropriation for a comprehensive set of legislative policy proposals that will continue to concentrate VA's health care resources to meet the needs of our highest priority core veterans. The MCCF of $2.8 billion increases by $779.1 million over the 2006 estimate. Of the $779.1 million, $544.4 million consists of collections from three legislative proposals: a proposed $250 annual enrollment fee ($225.6 million); an increase in pharmacy co-payments from $8 to $15 ($288.3 million); and eliminating the practice of reducing the VA first-party co-payment debts with collection recoveries from third-party health plans ($30.5 million). The remainder of the $234.7 million increase is for additional third-party insurance collections and pharmacy co-payments.

Medical Care Budget Authority (BA) for the Three Appropriations
(dollars in thousands)

	2005 Actual	2006 Estimate	2007 Estimate	Increase (+) Decrease (-)	Percent Change
Appropriation					
Medical services	$21,376,495	$22,547,141	$25,511,509	+$2,964,368	13.1%
Appn. prop. legisl. fees			-795,509 2/	-795,509	
Medical services total	21,376,495	22,547,141	24,716,000	+2,168,859	9.6%
Medical administration	3,310,427 1/	2,926,942	3,177,000	+250,058	8.5%
Medical facilities	3,263,040	3,297,669	3,569,000	+271,331	8.2%
Total appropriations	27,949,962	28,771,752	31,462,000	+2,690,248	9.4%
MCCF collections	1,868,383	2,053,641	2,832,778	+779,137	37.9%
BA before supplementals	**29,818,345**	**30,825,393**	**34,294,778**	**+3,469,385**	**11.3%**
Hurricane supplementals	106,932	198,265	0	-198,265	-100.0%
Avian flu supplemental	0	27,000	0	-27,000	-100.0%
Total budget authority	**29,925,277**	**31,050,658**	**34,294,778**	**+3,244,120**	**10.4%**
DoD portion of DoD VA HCSIF	15,000	15,000	0	-15,000	-100.0%
VHA Portion of VA IT Fund	1,124,933	794,811	817,082	+22,271	2.8%
Obligations 3 appropriations	**$29,708,964**	**$31,997,883**	**$35,002,778**	**+$3,004,895**	**9.4%**
FTE	**197,650**	**197,650**	**198,302**	**+652**	**0.3%**

1/ P.L. 109-114 created a new appropriation for VA Information Technology (IT) Systems in 2006 which resulted in moving VHA IT resources from Medical Administration (MA) to the VA IT Systems appropriation. In 2005, the VHA portion of the IT funding was appropriated in MA; however, this chart reflects the 2005 funding for MA without the VHA IT funding for comparison purposes.

2/ The President's budget includes a legislative proposal section that reduces the appropriation by $795.5 million as a result of three legislative proposals that will increase user fees.

To reflect the other resources associated with providing medical care to veterans, the table above also reflects funding for the Department of Defense (DoD) portion of the VA Health Care Sharing Incentive Fund (DoD VA HCSIF) and the VHA portion of the IT appropriation. The funding discussed in the remainder of this section does not include the IT appropriation in 2006 and 2007.

The sources and uses of funds for the medical care three appropriations are reflected in the following chart. The President's budget request is $31.5 billion in direct appropriation funding for all three appropriations. In addition, the veterans' medical program is funded by $2.8 billion in collections that come from veterans and their insurance companies. VA is reimbursed $266 million for services it provides to other federal and university affiliated medical programs. Lastly, VA medical programs can use the carryover of available prior-year funds that were not spent. In 2005, $1.15 billion was carried over into 2006 partially due to receiving the $1.5 billion supplemental in late 2005. Of the $1.15 billion carry over, $442 million is estimated to be carried over into 2007. In 2007, VA estimates that the three appropriations will obligate a total of $35 billion. The following chapter explains how these resources will provide medical care to our veterans.

Medical Care Three Appropriations Sources and Uses of Funds
(dollars in thousands)

	2005 Actual	2006 Estimate	2007 Estimate	Increase (+) Decrease (-)
Sources of funds				
Medical care appropriations (incl. supplementals)				
Medical services	$21,399,778	$22,757,406	$25,511,509	+$2,754,103
Appn. prop. legisl. fees	0	0	-795,509	-795,509
Medical services total	21,399,778	22,757,406	24,716,000	+1,958,594
Medical administration	3,312,367	2,926,942	3,177,000	+250,058
Medical facilities	3,329,749	3,297,669	3,569,000	+271,331
Subtotal three appropriations	28,041,894	28,982,017	31,462,000	+2,479,983
MCCF collections	1,868,383	2,053,641	2,832,778	+779,137
Reimbursements and prior-year recoveries	239,432	255,000	266,000	+11,000
Unobligated balance expiring	-2,660	0	0	+0
Carry over of prior-year funds	711,140	1,149,225	442,000	-707,225
Total sources	**30,858,189**	**32,439,883**	**35,002,778**	**+2,562,895**
Uses of funds				
Obligations				
Medical services	23,107,090	25,493,298	28,172,778	+2,679,480
Medical administration	3,291,221	3,075,252	3,229,000	+153,748
Medical facilities	3,310,653	3,429,333	3,601,000	+171,667
Subtotal three appropriations	**29,708,964**	**31,997,883**	**35,002,778**	**+3,004,895**
Remaining funds to be carried over into next year	**$1,149,225**	**$442,000**	**$0**	**-$442,000**

The Department of Veterans Affairs' (VA) health care system is widely recognized as a national leader in delivering high-quality care that sets the national standard of excellence in the health care industry. Whether compared to other federal health programs or private health plans, the quality of VA health care is unsurpassed. The Department continues to enhance quality, increase access, improve service satisfaction, and optimize patient functioning. It accomplishes these goals by continuing to provide services to veterans, such as dialysis care units and polytrauma centers, to improve the quality of their lives; delivering care through community-based outpatient clinics to improve access; initiating new collaborative arrangements with DoD to expand best practices from both health care communities; integrating new health care technologies to improve the quality of care; enhancing VHA's health information systems to standardize and increase the sharing of information for veterans and VA facilities; and ensuring a seamless transition for those who served in Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) as they move from the military health system to the VA health care system.

Medical Patient Case Load

From 1996 to 2003, VA experienced a significant increase of 64 percent in the total number of users. During this 7-year period, the percentage increase in comparatively higher income veterans (Priority 7-8) far exceeded the growth in the total patient population; the number of priority 7 and 8 patients was 12 times higher in 2003 than it was in 1996. This unprecedented growth led VA to suspend the enrollment of new Priority 8 veterans on January 17, 2003, in order to focus its resources on health care for the Department's core constituents. This budget assumes that VA will continue to suspend the enrollment of new Priority 8 veterans.

Although VA continued to experience growth in the medical patient case load in 2004 and 2005, it grew at a more moderate rate than in previous years. VA experienced an annual growth rate of 2.7 percent in 2005 as the number of patients treated increased from 5.2 million in 2004 to 5.3 million in 2005. During 2005, VA treated over 138,000 (4.1 percent) new patients among VA's highest priority veterans, Priority 1 through 6, and the number of Priority 7 and 8 veterans treated increased by over 10,000 (.8 percent).

VA continues to focus its health care system priorities on meeting the needs of our highest priority veterans. The number of patients within this core service population that we project will come to VA for health care in 2007 will be 7.1 percent higher than in 2005. During 2007, 72 percent of those using VA's health care system will be veterans with service-connected conditions, those with lower incomes, and veterans with special health care needs. The comparable share in 2005 was 67 percent. In addition, we devote 86 percent of our health care resources to meet the needs of these

veterans. Due to their advancing age and multiple medical problems, our highest priority veterans require much more extensive care which significantly increases our demand for more resources, on average, than for lower priority veterans. In 2007, VA anticipates treating 3.8 million in this core population, an increase over 2006 of 2.1 percent, or 79,961 new patients. In 2007, VA will treat 234,566 fewer Priority 7 and 8 patients, or 19 percent fewer patients. As a direct result of the legislative policies proposed in this budget, the Department expects to treat 199,667 fewer patients in the lower priority groups (Priorities 7-8) in 2007 as compared to the estimate for 2006.

Unique Patients

		2006			
Description	2005 Actual	Budget Estimate	Current Estimate	2007 Estimate	Increase/ Decrease
Priorities 1-6.....	3,561,709	3,690,605	3,733,496	3,813,457	79,961
Priorities 7-8 1/.....	1,301,283	1,019,461	1,237,144	1,002,578	-234,566
Subtotal Veterans.....	4,862,992	4,710,066	4,970,640	4,816,035	-154,605
Non-Veterans 2/...	445,322	491,008	471,312	482,588	11,276
Total Unique.....	5,308,314	5,201,074	5,441,952	5,298,623	-143,329

Enrollees

		2006			
Description	2005 Actual	Budget Estimate	Current Estimate	2007 Estimate	Increase/ Decrease
Priorities 1-6.....	5,311,090	5,557,704	5,412,360	5,521,291	108,931
Priorities 7-8 1/.....	2,344,472	1,256,861	2,163,586	1,104,224	-1,059,362
Total Enrollees.....	7,655,562	6,814,565	7,575,946	6,625,515	-950,431

Users as Percent of Enrollees

		2006			
Description	2005 Actual	Budget Estimate	Current Estimate	2007 Estimate	Increase/ Decrease
Priorities 1-6.....	67.1%	66.4%	69.0%	69.1%	0.1%
Priorities 7-8 1/.....	55.5%	81.1%	57.2%	90.8%	33.6%
Total Veterans.....	63.5%	69.1%	65.6%	72.7%	7.1%

1/ Priority 7 and 8 veterans are higher-income veterans with no service-connected disabilities.

2/ Non-veterans include spousal collateral consultations and instruction, CHAMPVA workload, reimbursable workload with affiliates, humanitarian care, and employees receiving preventive occupational immunizations.

To further address the increasing health care demand and to ensure that VA continues to provide timely, high-quality health care to our core population, the budget request includes cost-sharing policy proposals focused primarily on veterans who have no compensable service-connected disabilities and comparatively higher incomes. These proposals would require lower priority veterans to assume a greater share of the cost of their health care.

Although the overall veteran population is projected to decline over the next 10 years, the demand for VA health care services continues to increase due to the aging of veterans and the comprehensive health care services offered to veterans, including favorable pharmacy benefits; the national reputation of VA as a leader in the delivery of quality health care; long-term care services; and improved access to health care with the delivery of health care through community-based outpatient clinics.

Health Care Cost Drivers

VA will require $35 billion in total resources for 2007 to care for its 5.3 million patients. This is an increase in obligations of $3 billion over the 2006 estimate. There are three major cost drivers that account for the increased funding required in 2007 to meet the growing demand for VA health care services. These cost drivers are inflation, increased utilization of health care services, and greater intensity of health care services provided.

The cost of same market basket of products and services is greater in 2007 than in 2006 resulting in a total increase for inflation and payroll costs of $1.2 billion. This is comprised of an increase for payroll costs of $605.6 million and an increase in inflation of $559.7 million.

Overall utilization trends in the U.S. health care industry continue to increase. These trends increase the VA's cost of doing business regardless of any changes in enrollment, patients, or initiatives. For example, medical research indicates that taking a combination of cholesterol-lowering medications is more effective than a single medication. This practice increases the drug utilization trend. VA is also experiencing increased utilization of its medical services because of the demographics of its patient population and the reliance on VA's health care system which increases VA's cost of care. The patients who seek our care are aging, have lower incomes, and require more complex medical care. VA continues to experience an increased degree of reliance on its health care system. Although most veterans have access to multiple sources for their necessary medical treatment, such as Medicare, Medicaid, TRICARE, and private providers, they still rely on VA for a greater share of their health care needs due to the quality of VA's health care.

The trend in U.S. health care, as well as in VA, is to provide a greater intensity of medical services for the same type of patient and medical condition. Patients in the U.S. are provided more diagnostic tests, prescriptions, and medical services per patient each year. This trend increases the cost for some medical treatments such as the cost of pharmaceuticals and outpatient visits for each patient. VA requires additional funding in 2007 to provide this higher level of service.

Summary of Health Care Budget Request and Quality of Care

VA's request of $35 billion is comprised of three major components. First, VA is requesting additional resources of $3 billion to care for nearly 5.3 million unique patients. The $3 billion in obligations is comprised of an increase of $2.5 million for appropriation funding, $779.1 million for collections, and a net decrease of $254.2 million from reimbursements and utilization of prior year's unobligated funds.

The additional $3 billion funding requested in 2007 will deliver community-based health care to our eligible veterans. VA will provide a greater level of outpatient care to veterans who are scheduling appointments for more outpatient visits in the VA health care system. This outpatient care includes outpatient mental health programs to ensure that the veterans' mental health needs are adequately addressed. VA will treat a greater number of inpatients requiring acute care for general medical ailments and surgery than provided in 2006. Our veterans are also using an increasing number of prescription drugs; this coupled with increasing costs and more expensive medicines is driving up the cost of VA's pharmacy services. Additional funding is also required to purchase durable medical equipment to ensure our facilities have the right equipment to provide quality care to those who need it.

VA's goal is to restore the capability of veterans with disabilities to the greatest extent possible and improve their quality of life and that of their families. To achieve this goal, additional resources are needed for the following health care services. To improve the quality of life of the veterans we treat, VA requires more funding to buy prosthetics and sensory aids. From 2006 to 2007, the workload for these services grows from 1.7 million to 1.9 million unique patients, an increase of 12 percent or over 200,000 more patients. To care for VA's veterans who have special needs, an increase in funding is required to support our Regional Spinal Cord Injury Centers; provide inpatient rehabilitation programs at the Blind Rehabilitation Centers; and to care for those who need psychiatric care, who suffer from post-traumatic stress disorder (PTSD), who require substance abuse treatment, and who experience chronic mental illness and homelessness.

This request ensures that veterans or servicemembers returning with an injury from Operation Enduring Freedom and Operation Iraqi Freedom have timely access to the Department's special health care services. This includes treatment for spinal cord injuries, traumatic brain injuries, post-traumatic stress disorder, prosthetics, and rehabilitation of the blind. For active duty service members, Reservists, and members of the National Guard who served in a theater of combat operations, this budget includes funding for enrollment in the health care program assuring provision of hospital care, medical services, and nursing home care for a period of 2 years after their release from active military service at no cost to the veteran provided that the care is for any illness potentially related to their combat service.

These resources will support the Secretary's priority of providing timely and accessible health care that sets a national standard of excellence for the health care industry. To address this priority, VA has set two key goals for providing timely access to scheduled appointments for veterans. VA raised the percent of primary care appointments scheduled within 30 days of the desired date in 2005 to 96 percent and will maintain this level in 2006 and 2007. The percent of specialist appointments scheduled within 30 days of the desired date was 93 percent in 2005, and VA will maintain this level in 2006 and 2007.

Second, VA is proposing legislative proposals that will continue to focus the VA health care system on care for service-connected disabled veterans as well as veterans with lower incomes and those who have special health care needs. To ensure that VA continues to provide timely, high-quality health care to our core population, the proposals described below focus primarily on veterans who have no compensable service-connected disabilities and comparatively higher incomes:

- Assess an annual enrollment fee of $250 for all Priority 7 and 8 veterans. Priority 7 veterans have incomes above $26,903 for a single veteran and below the HUD geographic means test level. Priority 8 veterans are those with incomes above $26,903 for a single veteran and above the HUD geographic means test. The HUD geographic means test is established at a local level such as county.
- Increase a Priority 7 and 8 veteran's share of pharmacy co-payments from $8 to $15 for a 30-day supply of prescriptions paid by veterans who have a greater ability to absorb these co-payments. These two proposals are similar to those included in the 2007 President's budget for career military retirees under the age of 65 in the DoD health care system to align more closely with other public and private plans.
- Eliminate the practice of offsetting or reducing VA first-party co-payment debts with collection recoveries from third-party health plans. Veterans receiving medical care services for treatment of non-service connected disabilities will receive a bill for their entire co-payment, and this co-payment will not be reduced by collection recoveries from third-party health plans aligning VA with the DoD health care system for military retirees and the private sector. This proposal would apply to all veterans who make co-payments.

Third, VA is proposing additional clinical efficiencies and pharmaceutical cost efficiencies of $197 million in 2007 which partially offset the need for appropriated funds. VA estimates that it will achieve an additional $107 million in clinical efficiencies as the level of VA's health care management moves toward the private sector utilization benchmarks. VA expects to achieve an additional $90 million in pharmaceutical cost efficiencies over the 2006 level due to its formulary, robust management program, and negotiated discounted prices with drug companies.

Sharing of Health Care Delivery

The enhanced cooperative efforts between VA and DoD continue to underscore the health care delivery services that support both the President's Management Agenda and congressional mandates. The Departments have expanded their level of cooperation in a variety of critical areas identified in a Joint Strategic Plan (JSP) by the VA/DoD Joint Executive Council (JEC).

The JEC, co-chaired by the VA Deputy Secretary and the DoD Under Secretary for Personnel and Readiness, sets the priorities for the VA/DoD Health Executive Council (HEC) and the VA/DoD Benefits Executive Council (BEC). The HEC and BEC in turn, provide senior leader oversight for the JSP and serve as forums for interagency policy design and development to improve access to quality health care and reduce the cost of furnishing services to all beneficiaries. The VA/DoD Joint Executive Council is committed to the following accomplishments:

- The BEC will develop and execute an implementation plan designed to ensure that separating servicemembers receive a separation examination that meets both service separation requirements and VA disability compensation requirements.
- The BEC and HEC will continue to expand activities that support the sharing of health care data between VA/DoD, bi-directional and in real-time.
- The Construction Planning Committee (CPC) will identify three locations/ sites from the Base Realignment and Closure (BRAC) list that coincides with VA capital requirements as identified in the VA 5-Year Capital Plan and Capital Asset Realignment for Enhances Services (CARES).
- The HEC will develop and implement a shared training plan designed to increase coordination of education and training resources between VA and DoD.
- The HEC will assess VA/DoD processes related to the acquisition of goods and services and make recommendations to the JEC designed to achieve joint operational and business efficiencies.
- The HEC will work with industry to develop uniform identification codes for medical surgical products and will strive to secure a consensus with other federal partners on a standard naming/labeling format.
- The HEC will establish a joint Defense Supply Center, Philadelphia (DSCP)/VA Federal Supply Schedule (FSS) medical catalogue designed to allow VA and DoD customers to perform product and price comparisons for medical and surgical supplies, pharmaceutical items, and medical equipment.

In 2005, the cooperative efforts between VA and DoD increased the number of joint pharmacy contracts. As of November 29, 2005, there were 86 joint national pharmacy contracts and 10 blanket purchase agreements. These two Departments continued work to combine all the medical and surgical supply contracts by converting DoD's Distribution and Price Agreement (DAPA) to VA's Federal Supply Service (FSS) pricing to avoid redundancies. The Departments are building a single Federal

pricing catalog that will be searchable and available on-line for the Department's respective customers. The resultant product is to be released early 2007. There are no FY 2005 cost savings estimates at this time, and the data collection process is being developed. Cost avoidance for joint pharmaceutical contracts was $139 million in FY 2002, $148 million in FY 2003, and $185 million in FY 2004.

The Departments are working to eliminate duplicate contracting vehicles in the medical/surgical and equipment arenas. We have a total of 16 joint contracts in place. Nine contracts are for radiation oncology, five are for high-tech medical equipment maintenance and related services, one is for vital signs monitors, and one is for surgical instruments. VA and DoD added VA requirements to DoD's 25 hi-tech medical equipment contracts. Both Departments are currently ordering products from these contracts.

In 2005, the VA/DoD Health Executive Council approved 17 projects with a total cost of $30.5 million. Approved projects involve a wide range of services including cardiac and neurology surgery, mobile MRIs, and patient information exchange.

Summary of Resource Increases and Decreases

VA Medical Care [1/] Obligations by Program

Dollars in millions

	2005 Actual	2006 Estimate 2/	2007 Estimate 2/	Increase (+) Decrease (-)	Percent Change
Health care services					
Ambulatory care (includes outpatient mental health)	$10,685	$12,370	$14,005	+$1,635	13.2%
Inpatient hospital acute care	6,829	6,966	7,244	+278	4.0%
Pharmacy services	5,091	5,640	6,233	+593	10.5%
Prosthetics, durable medical equipment, & other	1,039	1,227	1,387	+160	13.0%
Special VA program bedsection care	892	965	1,034	+69	7.2%
Total health care services	**24,536**	**27,168**	**29,903**	**+2,735**	**10.1%**
Long-term care					
VA nursing home	2,441	2,310	2,391	+81	3.5%
Community nursing home	352	316	328	+12	3.8%
State nursing home	382	425	480	+55	12.9%
Total nursing home care	3,175	3,051	3,199	+148	4.9%
All other (subacute, respite, geriatric eval. & mgt.)	542	577	610	+33	5.7%
Total institutional care	3,717	3,628	3,809	+181	5.0%
Total non-institutional care	426	487	535	+48	9.9%
Total long-term care	**4,143**	**4,115**	**4,344**	**+229**	**5.6%**
Other health care programs					
CHAMPVA	527	597	665	+68	11.4%
Dental care	390	429	463	+34	7.9%
Readjustment counseling	82	99	106	+7	7.1%
Other	31	58	46	-12	-20.7%
Total other health care programs	**1,030**	**1,183**	**1,280**	**+97**	**8.2%**
Initiatives and legislative proposal					
2007 new initiatives	0	0	254	+254	
Prior-year policy and legislative initiatives	0	416	554	+138	33.2%
Total initiatives	**0**	**416**	**808**	**+392**	**94.2%**
Proposed policy proposals to focus care on high-priority veterans					
Assess $250 annual enrollment fee for P 7/8s	0	0	-184	-184	
Increase pharmacy co-pays from $8 to $15 for P 7/8s	0	0	-67	-67	
Total policy proposals	**0**	**0**	**-251**	**-251**	
Efficiencies 3/	**0**	**-884**	**-1,081**	**-197**	**22.3%**
Total obligations request	**$29,709**	**$31,998**	**$35,003**	**$3,005**	**9.4%**

1/ Summary of the Medical Services, Medical Administration, and Medical Facilities appropriations.
2/ The VHA portion of the IT account of $794,811,000 in 2006 and $817,082,000 in 2007 is not reflected in this funding because it was transferred from the Medical Administration appropriation to the VA IT Systems appropriation in 2006. In 2005, the VHA portion of the IT funding was appropriated in Medical Administration; however, this chart reflects the 2005 funding for MA without the VHA IT funding of $1,124,993,000 for comparison purposes.
3/ 2005 reflects $680 million of efficiencies spread throughout the various programs listed above.

In 2007, the medical care program requires an increase in total resources of $3 billion. The $3 billion in obligations is comprised of an increase of $2.5 million for appropriation funding, $779.1 million for collections, and a decrease of $254.2 million from reimbursements and utilization of prior-year's unobligated funds. These increases are offset by a savings of $795.5 million in appropriation for a comprehensive set of legislative policy proposals that will continue to concentrate VA's health care resources to meet the needs of our highest priority core veterans. The request also reflects an additional savings of $197 million in 2007 for clinical and pharmaceutical efficiencies. The programmatic changes, described below, highlight VA's major 2007 operational requirements.

Medical Care Programs Major Funding Changes. VA is requesting an increase in obligations of $3 billion, which represents a 9.4 percent increase over the 2006 estimate. VA's 2007 major initiatives that are designed to provide timely, high-quality health care to our core veterans are highlighted below. The funding in parenthesis represents the net change in obligations from the 2006 estimate to the 2007 request.

- **Health Care Services (increase of $2.7 billion).** VA projects increases for community-based health care that will be provided to 5.3 million users. **Ambulatory (outpatient) care** is provided to eligible veteran beneficiaries in VA hospital-based clinics and community-based clinics. This also includes outpatient mental health for such programs as day treatment centers, mental health for the homeless, methadone treatment, mental health intensive case management, work therapy, and community mental health residential care. VA estimates that the number of outpatient visits will increase from 62.1 million in 2006 to 65.6 million in 2007, an increase of 3.5 million, or 5.6 percent. **Inpatient hospital acute care** is delivered in VA hospitals and includes acute care for general medical ailments and surgery. VA estimates that the number of acute inpatients treated will increase from 559,076 in 2006 to 573,884 in 2007, an increase of 14,808, or 2.6 percent. The inpatient hospital average daily census (ADC) for acute care will increase from 9,084 in 2006 to 9,253 in 2007, an increase of 169, or 1.9 percent.

  Pharmacy services will increase the number of prescriptions from 121 million in 2006 to 124 million in 2007, an increase of 3 million, or 2.5 percent from 2006 to 2007. The significant increase in the cost of drugs is primarily due to the greater utilization of prescriptions by each veteran; utilization of more sophisticated, later generation drugs that are more expensive; and increases in unit-cost. **Prosthetics and durable medical equipment** increase to purchase and repair prosthetics and sensory aids such as artificial limbs and hearing aids and to buy durable medical equipment. **The special VA program bedsection care** provides services to veterans who require care for spinal cord injuries, inpatient blind rehabilitation, psychiatric care, post-traumatic stress disorder, substance abuse treatment, homelessness, and chronic mental illness.

- **Long-Term Care (increase of $229 million).** VA will continue to focus its long-term care treatment on the best setting for the patient by providing more noninstitutional care than ever before and providing that care closer to where the veteran lives. VA is requesting an additional $48 million, or a 9.9 percent increase for **non-institutional care** for home-based primary care, homemaker health aid services, and adult day health care services. VA is projecting an ADC level of over 36,000 for this progressive type of long-term care, an increase of over 4,000 ADC from the 2006 level. As more patients receive non-institutional care closer to home, the **VA nursing home care** ADC level will decrease from 11,151 in 2006 to 11,100 in 2007 and require a projected increase of resources of $81 million, a 3.5 percent increase, due to inflation and increased intensity of services. VA is projecting that the ADC for **contract community nursing home care** will remain at 3,844 in 2006 and 2007 and will require a projected increase of $12 million, a 3.8 percent increase due to rising costs. **State nursing home care** requires an additional $55 million in funding as the ADC increases from 18,383 to 19,414, an increase of 1,031 ADC or 5.6 percent. The **VA domiciliary residential and rehabilitation treatment program** and the **State home domiciliary program** require an additional $33 million in 2007.

- **Other Health Care Programs (increase of $97 million).** VA provides various other health care services which require additional funding in 2007. **The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)** number of claims will increase from 5.6 million in 2006 to 5.8 million claims in 2007, a 3.6 percent increase. This increase in the number of claims requires an additional $68 million in 2007, an 11.4 percent increase over the funding required in 2006. This program was established as a health benefits program for dependents of 100-percent rated, permanently and totally disabled veteran from a service-connected condition, survivors of veterans who died from service-connected conditions, or who at the time of death, were rated permanently and totally disabled from a service-connected condition. **Dental care** resources of an additional $34 million are required to provide additional one-time Class II benefits to discharged veterans of OIF/OEF. **Readjustment counseling** increases of $7 million are required to provide readjustment counseling to veterans who have served in the Global War on Terrorism. VA will have 207 Vet Centers in 2007 that are essential for accessing and treating post-traumatic stress disorder conditions experienced by our veterans. VA expects an increase in post-traumatic stress disorder conditions as veterans return from OIF/OEF after multiple tours of duty. **Other** results in a decrease of $12 million for one-time hurricane funding in 2006 that is not required in 2007.

- **Initiatives and a Legislative Proposal (an increase of $392 million).** VA is requesting funding for new or expanded initiatives in 2007 and prior-year policy and legislative initiatives.

- **2007 New or Expanded Initiatives (an increase of $254 million).** In 2007, VA is requesting an increase in funding for five new or expanded initiatives. **Prosthetics and sensory aids ($160 million)** funding is required to support the growth in VA's prosthetics workload from 1.7 million to 1.9 million unique patients, an increase of 12 percent or 208,278 unique patients. **Facility activations ($58 million)** require funding to buy equipment for newly constructed buildings and community-based outpatient clinics resulting from Capital Asset Realignment for Enhanced Services (CARES) projects. **The goal of the energy management program ($25 million)** is to reduce overall energy consumption by 35 percent by 2010 compared to the 1985 consumption. To accomplish this goal, funding is required to comply with program requirements, support mandatory energy audits, and perform non-recurring maintenance to reduce energy use. **Reimbursement funding for E-Gov is required to reimburse to the Department ($8 million)** for the e-Payroll project that encompasses the VA tasks required to manage the migration of VA payroll services to the Defense Finance and Accounting Service (DFAS). **The audit and execution tracking initiative ($4 million)** will consist of VA obtaining an independent audit to validate the actuarial model and undertaking the task of modifying the model's reporting against actual experience during the year.

- **Prior-Year Policy and Legislative Initiatives (an increase of $138 million).** There are three initiatives started in earlier years that also require additional funding in 2007. **The mental health initiative ($139 million),** developed in response to the President's New Freedom Commission on mental health recommendations, will deliver equitable access to care and an integrated system of mental health and substance abuse care that is readily available to veterans across the nation. This initiative, begun in 2005, ensures a full continuum of care for veterans with mental health issues, to include comprehensive treatment for those veterans with post-traumatic stress disorder. **Physicians pay (-$23 million)** funding increases in 2006 by $75 million to implement the pay provisions of the Department of Veterans Affairs Personnel Enhancement Act of 2004, P.L. 108-445. However, in 2007, only $52 million is required resulting in a decrease of $23 million. This decrease is related to VA's ability to hire physicians that VA previously paid for under contract. **The emergent care coverage ($24 million)** legislative proposal may be passed by Congress in 2006, and if this proposal is passed, it will require an additional $24 million in 2007. This legislative proposal would give VA the authority to pay for insured veteran patients' out-of-pocket expenses for urgent care services if their emergency or urgent care is obtained outside the VA health care system.

- **Proposed Policy Proposals to Focus Care on High-Priority Veterans (a decrease of $251 million).** VA is proposing a comprehensive set of legislative proposals designed to concentrate health care services on VA's highest priority veterans. These proposals described below focus primarily on veterans who have no compensable service-connected disabilities and comparatively higher incomes.

  - **Assess $250 Annual Enrollment Fee for Priority 7/8 (a decrease of $184 million).** VA is proposing to assess an annual enrollment fee of $250 for all Priority 7 and 8 veterans. This initiative results in a reduction in appropriation of $410 million comprised of a decrease of $184 million in workload and an increase in collections of $226 million.

  - **Increase Pharmacy Co-Payments for Priority 7/8 (a decrease $67 million).** VA is proposing to increase pharmacy co-payments from $8 to $15 for all Priority 7 and 8 veterans. This proposal will more closely align VA with other private and public health care plans. This initiative results in a reduction in appropriation of $355 million comprised of a decrease of $67 million in workload and an increase in collections of $288 million.

  - **Third-Party Offset of First-Party Debt ($0).** This proposal would align VA with the private sector plans by eliminating the practice of offsetting or reducing VA first-party co-payment debts with collection recoveries from third-party health plans. Veterans receiving medical care services for treatment of non-service connected disabilities will receive a bill for their entire co-payment, and this co-payment will not be reduced by collection recoveries from third-party health plans. This proposal would apply to all veterans who make co-payments. This initiative results in a reduction of appropriation of $30 million and an increase in collections of $30 million for a change in obligations of $0.

- **Pharmacy and Clinical Efficiencies (a decrease of $197 million).** VA is estimating additional efficiencies of $197 million over the 2006 level. VA estimates that it will achieve an additional $107 million in clinical efficiencies realized as the level of VA's health care management moves toward the private sector utilization benchmarks. VA expects to achieve an additional $90 million in pharmaceutical cost efficiencies over the 2006 level due to its formulary, robust management program, and negotiated discounted prices with drug companies.

Workloads and Workload Indicators

The 2007 budget provides for the medical care and treatment of 835,887 inpatients with an average daily census of 60,783 representing an increase of 2.3 percent. Outpatient medical visits will increase from 62.1 million to 65.6 million for an increase of 5.6 percent. Workloads and indicators of the medical care and treatment programs are shown in the following tables.

Summary of Workloads for VA and Non-VA facilities				
	2005 Actual	2006 Estimate	2007 Estimate	Increase(+) Decrease(-)
Outpatient visits (000s):				
Staff	52,343	55,541	58,513	+2,972
Fee	4,846	5,450	5,943	+493
Readjustment counseling	1,047	1,075	1,100	+25
Total	58,236	62,066	65,556	+3,490
Patients Treated:				
Acute hospital care	543,577	559,076	573,884	+14,808
Rehabilitative care	15,253	15,429	15,493	+64
Psychiatric care	109,604	109,132	108,767	-365
Nursing home care	99,158	94,562	96,474	+1,912
Subacute care	13,216	12,663	12,184	-479
Residential care	30,472	29,595	29,085	-510
Total inpatient facilities	811,280	820,457	835,887	+15,430
Average Daily Census:				
Acute hospital care	8,961	9,084	9,253	+169
Rehabilitative care	1,210	1,210	1,210	+0
Psychiatric care	4,363	4,340	4,286	-54
Nursing home care	34,375	33,378	34,358	+980
Subacute care	399	345	327	-18
Residential care	9,015	11,035	11,349	+314
Total inpatient facilities	58,323	59,392	60,783	+1,391
Home and community-based care	27,469	32,105	36,722	+4,617
Grand Total (inpatient and H&CBC)	85,792	91,497	97,505	+6,008
Length of Stay:				
Acute hospital care	6.0	5.9	5.9	+0.0
Rehabilitative care	29.0	28.6	28.5	-0.1
Psychiatric care	14.5	14.5	14.4	-0.1
Nursing home care	126.5	128.8	130.0	+1.2
Subacute care	11.0	9.9	9.8	-0.1
Residential care	108.0	136.1	142.4	+6.3

Summary of Workloads for VA and Non-VA facilities (continued)				
	2005 Actual	2006 Estimate	2007 Estimate	Increase(+) Decrease(-)
Staff and fee outpatient dental program:				
Staff examinations	548,734	630,000	649,000	+19,000
Staff treatments	338,048	389,000	401,000	+12,000
Fee cases	26,007	30,000	31,000	+1,000
CHAMPVA workloads: 1/				
Inpatient census	597	619	629	+10
Outpatient claims (CHAMPVA/CHAMPVA for Life) (000s)	5,178	5,600	5,800	+200

1/ CHAMPVA care for certain dependents and survivors of veterans is provided in both inpatient and outpatient settings.

Employment Analysis *FTE*				
	2005 Actual	2006 Estimate	2007 Estimate	Increase(+) Decrease(-)
FTE by appropriation				
Medical services	135,283	135,283	135,935	+652
Medical administration	35,652	35,652	35,652	+0
Medical facilities	26,715	26,715	26,715	+0
Total FTE	197,650	197,650	198,302	+652
FTE by activity				
Acute hospital care	50,455	50,373	50,384	+11
Rehabilitative care	4,199	4,260	4,260	+0
Psychiatric care	10,988	10,988	11,603	+615
Nursing home care	22,455	22,438	22,438	+0
Subacute care	1,437	1,421	1,410	-11
Residential care	3,784	3,799	3,799	+0
Outpatient care	103,857	103,873	103,873	+0
CHAMPVA	475	498	535	+37
Total FTE	197,650	197,650	198,302	+652

The VA installations by category are provided below.

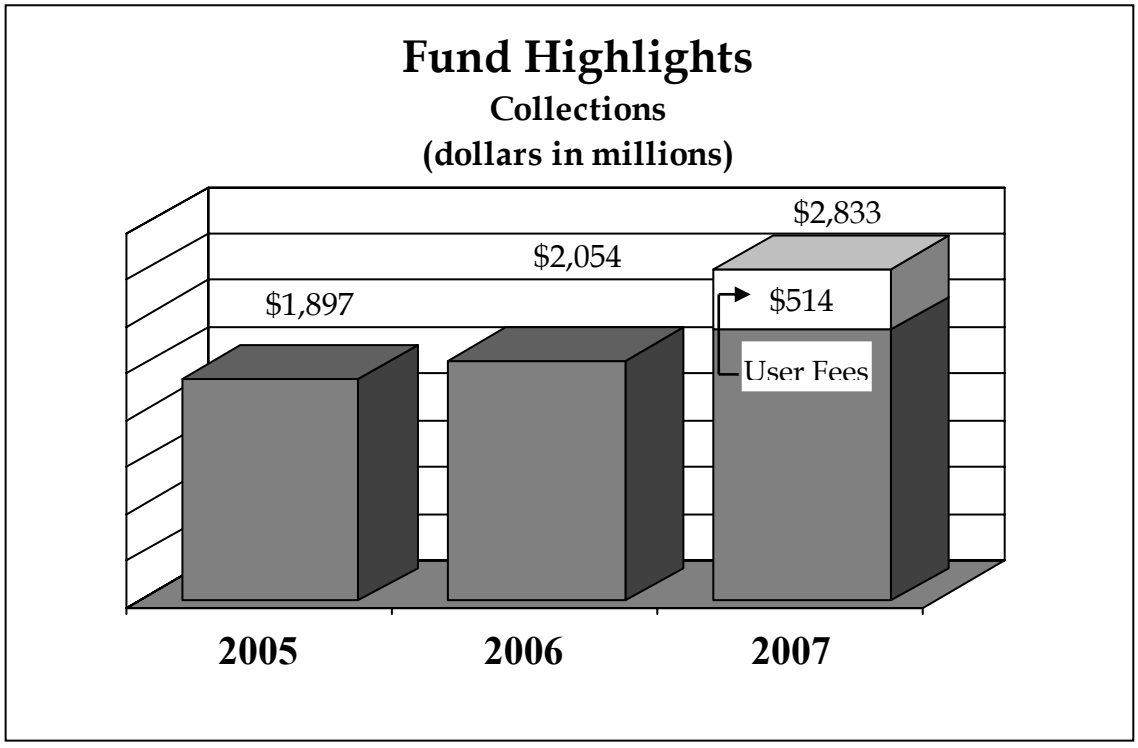
Medical Care *Number of VA Installations*				
	2005 Actual	2006 Estimate	2007 Estimate	Increase(+) Decrease (-)
Veterans integrated service networks	21	21	21	+0
VA hospitals 1/	156	156	156	+0
VA nursing homes 2/	135	135	135	+0
Domiciliary residential rehabilitation treatment programs	43	43	43	+0
Independent outpatient clinics	4	4	4	+0
Mobile outpatient clinics	5	5	5	+0
Veterans centers	206	207	207	+0

1/ Continues to reflect facilities in New Orleans, LA, and Gulfport, MS, damaged by Hurricane Katrina.
2/ Continues to reflect the facility in New Orleans, LA, damaged by Hurricane Katrina.

Medical Care Collections Fund

VA estimates collections of more than $2.8 billion, representing over 8 percent of the available resources in 2007 and an increase of $779.1 million, a 38 percent increase over the 2006 estimate. This fund consists of collections from pharmacy co-payments, third-party insurance collections, first-party other co-payments, enhanced-use revenue, long-term care co-payments, Compensated Work Therapy Program, Parking Program, and Compensation and Pension Living Expenses Program. Public Law 105-33, the Balanced Budget Act of 1997, established the Department of Veteran Affairs Medical Care Collections Fund (MCCF) and requires that amounts collected or recovered after June 30, 1997, be deposited in this fund.

Of the $779.1 million increase in collections, $544.4 million consists of collections that would result from three proposed legislative proposals: a proposed $250 annual enrollment fee ($225.6 million); an increase in pharmacy co-payments ($288.3 million); and eliminating third-party offset of first-party debt ($30.5 million). The remainder of the $234.7 million increase is for additional third-party insurance collections and pharmacy co-payments.



Medical Care Collections Fund Summary of Fund *(dollars in thousands)*				
	2005 1/ Actual	2006 Estimate	2007 2/ Estimate	Increase (+) Decrease (-)
Pharmacy co-payments	$648,204	$700,758	$807,500	+$106,742
Third-party insurance collections	1,055,597	1,178,476	1,304,428	+125,952
First-party other co-payments	118,626	119,876	119,876	+0
Enhanced-use revenue	26,861	625	625	+0
Long-term care co-payments	5,411	5,964	6,204	+240
Compensated work therapy collections	36,516	43,764	45,515	+1,751
Parking fees	3,443	3,500	3,500	+0
Compensation & pension living expenses	2,431	678	705	+27
Subtotal	1,897,089	2,053,641	2,288,353	+234,712
Legislative proposal:				
Third-party offset of first-party debt	0	0	30,496	+30,496
Proposed legislation, user fees				
Increase pharmacy co-payment for P 7/8s	0	0	288,313	+288,313
Assess $250 enrollment fee	0	0	225,616	+225,616
Subtotal proposed legislation, user fees	0	0	513,929	+513,929
Total collections	**$1,897,089**	**$2,053,641**	**$2,832,778**	**+$779,137**

1/ These numbers reflect collections of $1,897,088,895 received by VA in 2005. Due to the difference in the timing from when the funds are received and transferred into the medical care account, other charts reflect $1,868,383,204 transferred to the medical services account in 2005. The remainder of the funds collected in 2005 will be transferred in 2006.

2/ The President's budget includes a legislative proposal section that increases collections by $544.4 million as a result of three legislative proposals that propose to increase user fees.

Improving Collections in the Future

- With the establishment of the VHA Chief Business Office (CBO) an expanded revenue improvement strategy has been formulated that combines the 2001 Revenue Improvement Plan with a series of additional tactical and strategic objectives targeting a combination of immediate, mid-term, and long-term improvements to the broad range of business processes encompassing the VA's revenue activities. Following guidance articulated in the President's Management Agenda, the Chief Business Office has pursued its current revenue improvement strategy by modeling industry best performance. To that outcome, the strategies now being pursued include establishment of industry-based performance and operational metrics, development of technology enhancements, and integration of industry proven business approaches including the establishment of centralized revenue operation centers.

- VHA is implementing a private-sector based business model pilot that is tailored for VHA revenue operations to increase third-party insurance revenue and improve VA operational performance. The pilot Consolidated Patient Account Center (CPAC) will address all operational areas contributing to the establishment and management of patient accounts and related billing and collection processes. As successful milestones are completed during the demonstration period, it is envisioned that VHA will begin to migrate to a multi-Veterans Integrated Systems Network (VISN) model, to include the investment in state-of-the-art technology and physical plant designed to accommodate the staffing and processing volume associated with all of the medical facilities in CPAC's servicing region that could range in size from one to four VISNS, or 18 to 20 medical facilities. The multi-VISN/facility VHA architecture would be specifically designed for an optimum number of national processing centers to maximize the return on investment. The first CPAC is being piloted in the VA Mid-Atlantic Health Care Network, VISN 6, during FY 2006. Based on proof of concept in FY 2006, the CPAC will be ready to assume workload from additional networks.

- VA is working with the Centers for Medicare/Medicaid Services (CMS) contractors for the purpose of providing VA with a Medicare-equivalent remittance advice (MRA) for veterans who are using VA services and are covered by Medicare. These MRAs will reflect the deductible and coinsurance amounts that Medicare supplemental insurers will use to reimburse VA for health care services that VA provided to veterans for their non-service connected treatment. In September 2005, VA completed implementation of the first iteration of MRA solution. The MRA project enables improved accuracy in accounting for receivables as well as improved accuracy of payments to VA by providing accurate information for the adjudication of claims.

- Leveraging the health care industry's migration to national standard electronic data exchanges under the Health Insurance Portability and Accountability Act (HIPAA), the following initiatives are underway to add efficiencies to the billing and collections processes.

    - The electronic Insurance Identification and Verification (e-IIV) project is providing VA medical centers (VAMCs) with an automated mechanism to obtain veterans' insurance information from health plans that participate in the electronic data exchange. VA is also pursuing data-sharing opportunities that may offer greater access to other health insurance information.

    - The electronic Payments or Third-Party Electronic Data Interchange Lockbox (e-Payments) initiative was implemented in October 2003. e-Payments enables the receipt and posting of third-party electronic payments and remittance advices from health plans against third-party health care claims. Software

enhancements have been deployed to allow for more efficient processing of electronic payments and improved reporting capabilities. When insurers fully use the e-Payments system, collections are processed as much as 43 percent faster (with Electronic Funds Transfer), and there is an average 64 percent overall time saving on tasks related to receipt of payments and closeout of accounts. Until all payers fully transition to HIPAA capability, the complete benefits of the software will not be realized.

- Enhancements to existing electronic Claims (e-Claims) software are underway in VA to improve reports and to enable electronic coordination of benefits for secondary claims.

- The e-Pharmacy Claims software is currently completing testing. The addition of this functionality in the VistA system provides electronic outpatient pharmacy claims processing using the HIPAA-compliant NCPDP transaction version 5.1. This enhancement provides real-time claims adjudication for outpatient pharmacy claims. VA is also working with payers on acceptance of VA's predominantly 90-day prescription fills; these are beneficial to veterans and more economical for VA but require business and/or system modifications on the part of many payers.

- In accordance with HIPAA, after May 23, 2007, the National Provider ID (NPI) will be required for VHA in standard electronic health care transactions. NPIs are required for VHA organizational entities and all health care practitioners providing billable services to VHA. In addition to an enumeration project for VHA organizational and individual providers, an e-Business project has been initiated to support the use of NPIs in HIPAA-standard electronic transactions.

- The VA is currently working on a congressionally-directed pilot project which involves the replacement of the VistA billing and accounts receivable software products with commercial-off-the-shelf (COTS) patient management, billing, and accounts receivable software. The Patient Financial Services System (PFSS) pilot encompasses both the integration of the COTS software into the VistA clinical environment and the introduction of improved business processes. The benefits of PFSS include significant automation enhancement, single master insurance file, automated exception work lists, defined universe of cases, improved denials management, and bed control functionality. The objectives of the PFSS pilot include the following:
  - increasing the accuracy of bills and documentation;
  - reducing operating costs;
  - complying with VA and Centers for Medicare and Medicaid Services (CMS) policies;
  - generating additional revenue;

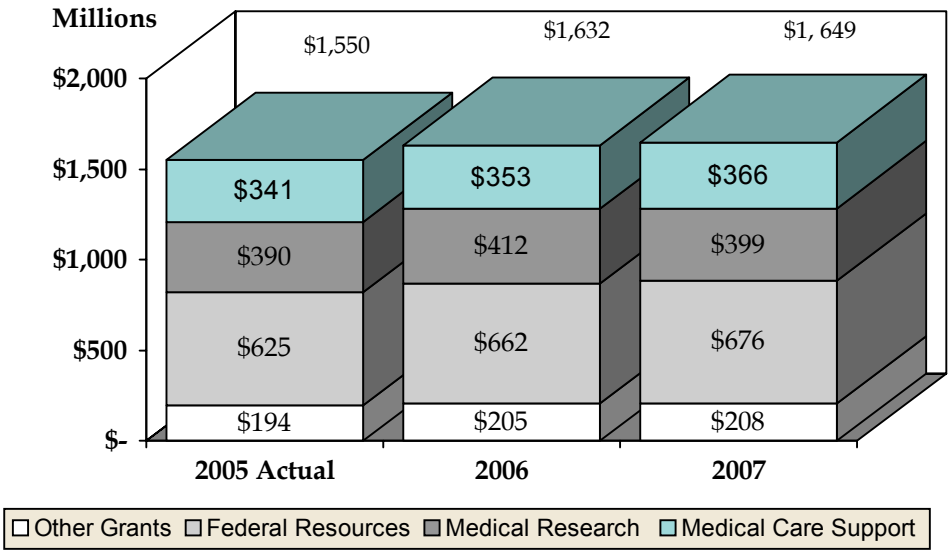
- reducing outstanding accounts receivable;
- increasing accuracy of bills to and payments received from insurance carriers; and
- enhancing data capture and integrity and decreasing the time to bill.

Medical and Prosthetic Research

Medical and Prosthetic Research is an intramural program, whose mission is to advance medical knowledge and create innovations to advance the health and care of veterans and the nation. It supports research that facilitates and improves the primary function of VHA, which is to provide high quality and cost-effective medical care to eligible veterans and contribute to the Nation's knowledge on disease and disability. This appropriation provides funds for the conduct of the VA's Biomedical, Clinical Science, Health Services, and Rehabilitation research programs.

Overall, VA is budgeting $1.6 billion in total research resources for 2007 and anticipating a $17.3 million increase in funding, or 1 percent. For direct appropriation, VA is requesting $399 million. The total research increase of $17.3 million is primarily due to non-VA grant funding from federal and private research programs. The Medical and Prosthetic Research appropriation request of $399 million supports 24 percent of the research effort, with the balance coming from other Federal appropriations as well as private sources.

Summary of Budgetary Resources



Medical Care Research support contributes funding towards the indirect cost of VA's Research and Development program which is estimated to be $366 million in 2007. This includes: facility costs of heat, light, telephone, and other utilities associated with laboratory space; administrative cost of human resource support, fiscal service, and supply service attributable to research; research's portion of a medical center's hazardous waste disposal and nuclear medicine licenses; and, most importantly, the time clinicians devote to their research activities. Over 76 percent of VA investigators are clinicians, who provide direct patient care to veterans in addition to performing research.

The Medical and Prosthetic Research and Medical Care Support funding are part of the budgetary resources that supports VA's research initiative. Non-VA Federal and Other grants also contribute to The Medical and Prosthetic Research budgetary resources. Non-VA funding comes from other federal and private medical research organizations such as the Department of Defense and National Institute of Health. This overall level of funding will allow the research program to maintain research centers in the areas of Gulf War illnesses, PTSD/mental health, diabetes, heart disease, chronic viral diseases (e.g., HIV/AIDS), Parkinson's disease, spinal cord injury, prostate cancer, depression, environmental hazards, and women's issues, as well as rehabilitation and Health Services Research and Development (HSR&D) field programs. VA will continue to seek to increase non-appropriated research funding from the private and public sectors. The 2007 request will maintain the research effort directed towards improving veterans health and care.

VA will realign its research funding to focus on those programs that are most important to the health care of veterans. The following table summarizes the budgetary resources for the Medical and Prosthetic Research activities. In addition to receiving direct support for VA initiated research from appropriated funds, VA clinician/investigators compete for and obtain funding from other Federal and non-Federal sources. Their success is a direct reflection of the high caliber of VA's corps of researchers who are able to work in an environment conducive to research.

Summary of Resources *(dollars in thousands)*				
	2005 Actual	2006 Estimate	2007 Estimate	Increase(+) Decrease(-)
Medical and Prosthetic Research 1/	$390,224	$412,000	399,000	-$13,000
Medical Care Support	340,613	353,000	366,000	+13,000
Federal Resources	624,800	662,288	675,534	+13,246
Other Grants (voluntary agencies)	194,700	204,435	208,524	+4,089
Total	$1,550,337	$1,631,723	$1,649,058	+$17,335

1/ In FY 2006, Congress established an Information Technology (IT) centralized appropriation for all VA non-Payroll expenditures for 2005. Excluded from the 2005 actual obligations is $12,124,000 for IT. This amount will need to be added back to 2005 for the actual total obligation figure.

Veteran health issues are addressed comprehensively in the four program divisions as follows:

Biomedical Laboratory Science Research and Development Service – Supports preclinical research to understand life processes from the molecular level in regard to diseases affecting veterans. This is one of the President's Interagency Science and Technology Priorities.

Clinical Science Research and Development Service – Administers investigations (e.g., human subject research such as drug, surgical, single subject, pilot and multi-center cooperative studies as well as feasibility trials) aimed at instituting new, more effective clinical care.

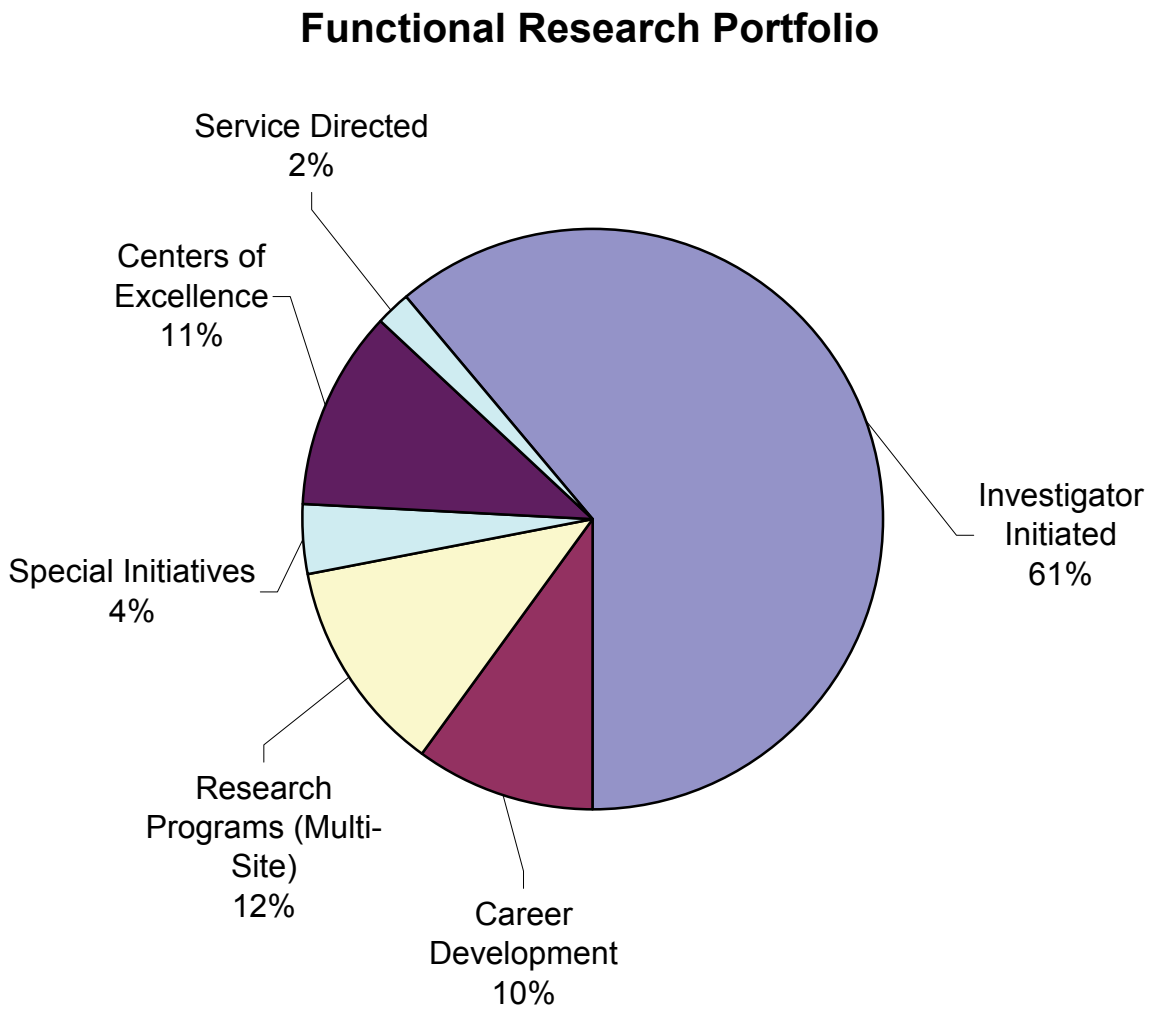
Health Services Research and Development Service – Identifies and promotes effective and efficient strategies to improve the organization, cost effectiveness, and delivery of health care at the patient and systems level.

Rehabilitation Research and Development Service – Administers investigations from bench to early clinical and small clinical trials to develop novel clinical treatments for the rehabilitation of veterans returning from all deployments, including Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF), so that all those with traumatic amputation, central nervous system injuries, loss of sight and/or hearing, or other physical and cognitive impairments can return to full and productive lives.

The Medical and Prosthetic Research appropriation in 2007 totals $399 million and is supported by 2,839 FTE. It will provide 24 percent of the $1.6 billion total research funding and support 2,045 high-priority research projects. The number of projects funded for 2007 has been reduced by 66.

Obligations, Budget Authority, and Employment (dollars in thousands)				
	2005 Actual	2006 Estimate	2007 Estimate	Increase (+) Decrease (-)
Medical and Prosthetic Research:				
Obligations	$457,148	$473,264	$454,000	-$19,264
Average employment (FTE):				
Direct	2,946	2865	2,579	-286
Reimbursable	260	260	260	0
Total	3,206	3,125	2,839	-286
Appropriation	$405,593	$412,000	$399,000	-$13,000
Rescission (Research)	-3,245	0	0	0
IT removed for comparison purposes	-12,124	0	0	0
Total	$390,224	$412,000	$399,000	-$13,000
Outlays:				
Obligations	$457,148	$473,264	$454,000	-$19,264
Obligated balance, start of year	122,824	139,867	165,002	+25,135
Obligated balance, end of year	-139,867	-165,002	-177,944	-12,942
Reimbursements	-55,325	-45,000	-45,000	+0
Adjustments in accounts	-7,145	0	0	+0
Total Outlays (net)	$377,635	$403,129	$396,058	-$7,071

The Functional Research Portfolio pie chart that follows shows the distribution of VA's research among five different types of investigative approaches. The investigator-initiated research and multi-site trials portion of the portfolio make up 73 percent of the entire program. This is indicative of the openness of the system to new ideas.



Percentages are based on 2007 Obligations

In 2007, the research program will continue its strong support of projects originated in prior years. In addition, it will continue its strong commitment and increased emphasis on Designated Research Areas (DRAs) highly relevant to the health care needs of veterans.

Projects by Designated Research Areas				
	2005 Actual	2006 Estimate	2007 Estimate	Increase (+) Decrease (-)
Designated Research Areas:				
Aging	227	224	206	-18
Cancer	269	266	233	-33
Infectious Diseases	118	118	108	-10
Kidney Diseases	84	83	73	-10
Diabetes and Major Complications	114	114	104	-10
Lung Disorders	84	84	77	-7
Heart Diseases	217	214	195	-19
Other Chronic Diseases	9	9	8	-1
Mental Illness	173	185	190	+5
Substance Abuse	91	91	94	+3
Sensory Loss	106	106	111	+5
Acute and Traumatic Injury	115	115	139	+24
Health Systems	214	219	201	-18
Special Populations	50	50	46	-4
Military Occupations & Environmental Exposures	113	153	157	+4
Emerging Pathogens/Bio-Terrorism	9	10	9	-1
Digestive Diseases	110	109	99	-10
Autoimmune, Allergic, and Hematopoietic Disorder	103	102	93	-9
CNS Injury and Associated Disorders	177	186	204	+18
Degenerative Diseases of Bones and Joints	50	51	45	-6
Dementia and Neuronal Degeneration	71	71	72	+1

The Designated Research Areas (DRA) listed above represent areas of particular importance to our veteran population. Because of the multiplicative nature of research, many individual research projects have a bearing on more than one DRA. For example, heart disease relates both to chronic disease and aging. This research helps us perform our mission "to discover knowledge and create innovations that advance the health and care of veterans and the nation."

VA/DoD Health Care Sharing Incentive Fund

To facilitate the incentive program, effective October 1, 2003, there is established in the Treasury a fund to be known as the "DoD VA Health Care Sharing Incentive Fund." Each Secretary shall annually contribute to the fund a minimum of $15 million from the funds appropriated to that Secretary's Department. Such funds shall remain available until expended.

In 2005, 17 projects were selected to be funded through DoD/VA Health Care Sharing Incentive Fund and similar projects will be supported with 2007 funding. These included the following types of projects which attempt to coordinate the VA and DoD health care process and take advantage of synergies available for efficient and effective care for our Nation's veterans: TRICARE Management Activity, Cardiac Surgery coordinated program, Pain Management Improvement, Neurosurgery Program, Mobile MRI and Healthcare Planning Data Mart, and VHA Central Office Defense Supply Center.

Fund Highlights
(dollars in thousands)

Description	2005 Actual	2006 Estimate	2007 1/ Estimate	Increase (+) Decrease (-)
Transfer from Medical Services	$15,000	$15,000	$0	-$15,000
Transfer from DoD	$15,000	$15,000	$0	-$15,000
Budget Authority Total	$30,000	$30,000	$0	-$30,000
Obligations	$5,549	$20,000	$30,000	+10,000

1/ After the appropriations act is passed, VA and DoD will transfer $15 million each, as required by P.L. 107-314 which established the program.

Canteen Service Revolving Fund

Current revenues finance this revolving fund and provide for the maintenance and operation of the Veterans Canteen Service at all VA hospitals and domiciliaries. The canteens provide reasonably priced meals, merchandise, and services to comfort veterans in hospitals, nursing homes, and domiciliaries.

Fund Highlights
(dollars in thousands)

	2005 Actual	2006 Estimate	2007 Estimate	Increase (+) Decrease (-)
Obligations	$249,083	$251,950	$252,125	+$175
Revenue	$246,787	$247,900	$253,459	+$5,559
Expense (-)	-$246,477	-$244,910	-$249,732	+$4,822
Net operating income	$310	$2,990	$3,727	+$737
Non-operating income (+) or loss (-)	+$342	+$50	+$60	+$10
Net income	$652	$3,040	$3,787	+$747
Outlays (net)	$-5,813	$1,439	$-120	-$1,559
Average employment	2,952	2,940	2,950	+10

Medical Center Research Organizations

Veterans' Benefits and Services Act of 1988 (Public Law 100-322) authorized "Medical Center Research Organizations" to be created at Department of Veterans Affiars medical centers. This program has been known as the "Medical Center Research Organizations" after Congress expanded the Non-profit Research Corporations authority to include education (Public Law 106-117). This public law authorizes Department of Veterans Affairs' medical center nonprofit organizations to provide a flexible funding mechanism for the conduct of research. These organizations derive funds to operate various research activities from Federal and non-Federal sources. This fund is self-sustaining and requires no appropriation to support these activities.

Fund Highlights
(dollars in thousands)

	2005 Actual	2006 Estimate	2007 Estimate	Increase (+) Decrease (-)
Contributions	$186,633	$180,000	$190,000	+$10,000
Obligations (expenses)	$180,460	$180,000	$184,000	+$4,000

General Post Fund, National Homes

This trust fund is used to promote the comfort and welfare of veterans in hospitals and homes where no general appropriation is available. The fund consists of gifts, bequests, and proceeds from the sale of property left in the care of VA facilities by former beneficiaries who die leaving no heirs or without having otherwise disposed of their estate. Donations from pharmaceutical companies, nonprofit corporations, and individuals to support VA medical research can also be deposited into this fund.

No appropriation funding is being requested for the transitional housing loan program for 2007 because no loan activity on this program has occurred since its inception in September 1994.

Obligations and Budget Authority
(dollars in thousands)

	2005 Actual	2006 Estimate	2007 Estimate	Increase (+) Decrease (-)
Program:				
Obligations	$29,560	$31,391	$32,945	+$1,554
Budget authority (permanent, indefinite)	$30,926	$32,555	$33,354	+$799